		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005637

Facility Name: St Joseph Nursing Home

Address: 401 Ninth Street (Number) Lacon (City) 61540 (Zip Code)

County: Marshall

Telephone Number: (309) 246-2175 **Fax #** (309) 246-3609

IDPA ID Number: 0005637

Date of Initial License for Current Owners: 5 / 7 / 1965

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dwayne Richardson **Telephone Number:** (314) 692-5886

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2001 to 6/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Thomas E. Becher
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Dwayne Richardson, Principal
(Firm Name & Address) CBIZ Business Solutions of St. Louis, Inc., One CityPlace Drive, Suite 570, St. Louis, MO 63141
(Telephone) (314) 692-5886 Fax # (314) 692-4222

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds Not applicable

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	33,945	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,936	14,109		33,045	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,936	14,109		33,045	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.35%

D. How many bed-hold days during this year were paid by Public Aid?
83 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None.

F. Does the facility maintain a daily midnight census? Yes.

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5 / 7 / 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary Not applicable

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 7/1/01-6/30/02 Fiscal Year: 7/1/01-6/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,612		21,733	314,345	(28,995)	285,350	(53,727)	231,623			1
2	Food Purchase		210,539		210,539	(19,420)	191,119	(42,650)	148,469			2
3	Housekeeping	91,622	13,308		104,930		104,930		104,930			3
4	Laundry	80,289		14,198	94,487		94,487		94,487			4
5	Heat and Other Utilities			98,678	98,678		98,678	(3,648)	95,030			5
6	Maintenance	59,520		21,479	80,999		80,999		80,999			6
7	Other (specify):*											7
8	**TOTAL General Services**	524,043	223,847	156,088	903,978	(48,415)	855,563	(100,025)	755,538			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,280,447	61,306	6,173	1,347,926	(3,786)	1,344,140		1,344,140			10
10a	Therapy											10a
11	Activities	96,272	4,356	2,501	103,129		103,129		103,129			11
12	Social Services	91,127	568	1,845	93,540		93,540		93,540			12
13	Nurse Aide Training					6,130	6,130		6,130			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,467,846	66,230	10,519	1,544,595	2,344	1,546,939		1,546,939			16
	C. General Administration											
17	Administrative	121,020			121,020		121,020		121,020			17
18	Directors Fees											18
19	Professional Services			54,071	54,071		54,071		54,071			19
20	Dues, Fees, Subscriptions & Promotions			18,740	18,740		18,740	(8,038)	10,702			20
21	Clerical & General Office Expenses	87,620	11,907	29,967	129,494		129,494	(6,454)	123,040			21
22	Employee Benefits & Payroll Taxes			483,558	483,558	48,415	531,973	(10,724)	521,249			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,959	9,959	(2,344)	7,615	(866)	6,749			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,700	11,700		11,700		11,700			26
27	Other (specify):*											27
28	**TOTAL General Administration**	208,640	11,907	607,995	828,542	46,071	874,613	(26,082)	848,531			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,200,529	301,984	774,602	3,277,115		3,277,115	(126,107)	3,151,008			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Joseph Nursing Home #0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,173	2,173		2,173		2,173			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* DEPRECIATION			71,332	71,332		71,332	(13,599)	57,733			36
37	**TOTAL Ownership**			73,505	73,505		73,505	(13,599)	59,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,016	2,016		2,016		2,016			39
40	Barber and Beauty Shops		520	13,882	14,402		14,402		14,402			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,917	50,917		50,917		50,917			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		520	66,815	67,335		67,335		67,335			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,200,529	302,504	914,922	3,417,955		3,417,955	(139,706)	3,278,249			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,705)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,909)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,037)	36		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(105,645)	attch		15
16	Personal Expenses (Including Transportation)	(1,545)	21		16
17	Non-Care Related Fees	(961)	2		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,038)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(866)	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,706)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,706)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ST. JOSEPH'S NURSING HOME, INC.
SCHEDULE VI, PAGE 5 - ADJUSTMENT DETAIL
YEAR ENDED JUNE 30, 2002

G/L ACCT #	ACCOUNT DESCRIPTION	SCHEDULE VI DESCRIPTION	Sch VI Line # Ref		Sch VI Per CR 6/30/2001	Sch V Line # Ref	
781029	CAFETERIA	NON-PATIENT MEALS	4	$	(5,705)	**2**	
410030	CABLE TV	TELE, TV, AUDIO IN PATIENT ROOMS	5	$	(4,909)	**21**	
VARIOUS	FROM C/R PAGE 13	NON-STRAIGHT-LINE DEPRECIATION	9	$	(12,037)	**36**	
804100	DISCOUNTS EARNED	DISCS, ALLOWS, REBATES & REFUNDS	11	$	-	**2**	
VARIOUS	FROM RECLASS & ADJUST WORKSHEET	NON-CARE RELATED OWNER TRANSACTIONS	15	$	(105,645)	**VARIOUS**	**(SEE SCH V - RECLASSES & ADJUSTMENTS)**
347002	MISC REVENUE	PERSONAL EXPENSES (INCL TRANSPORTATION)	16	$	(946)	**21**	
350021	EMPLOYEE PURCHASES	PERSONAL EXPENSES (INCL TRANSPORTATION)	16	$	(599)	**21**	
805100	VENDING MACHINES	NON-CARE RELATED FEES	17	$	(961)	**2**	
410049	ADVERTISING & PUBLIC RELATIONS	FUND RAISING, ADVERTISING & PROMO	25	$	(8,038)	**20**	
350020 and 805550	CNA TUITION REIMBURSEMENT	OTHER - NURSE AIDE TRAINING REIMBURSEMENT	29	$	(866)	**24**	
			TOTALS	**$**	**(139,706)**		

ST. JOSEPH'S NURSING HOME, INC.
SCHEDULE V, PAGES 3 AND 4 - RECLASSES AND ADJUSTMENTS
YEAR ENDED JUNE 30, 2002

Reclassifications Nurse Aide Training Programs:

Nursing and medical records costs	$ 1,347,926	*From page 3, Line 10, Col. 4*
(Less): In-house nurse aide trainer wages	$ (3,786)	***Reclass: From Line 10; To Line 13, Schedule V***
Nursing and medical records costs, net of in-house trainer wages	**$ 1,344,140**	
Travel and seminar costs	$ 9,959	*From page 3, Line 24, Col. 4*
(Less): External nurse aide trainer costs	$ (1,594)	***Reclass: From Line 24; To Line 13, Schedule V***
(Less): Nurse aide training supplies and tests	$ (750)	***Reclass: From Line 24; To Line 13, Schedule V***
Travel and seminar costs, net of nurse aide training supplies and tests	**$ 7,615**	
Total Reclassifications for Nurse Aide Training Programs	**$ (6,130)**	

Patient, Sister and Employee Meals:

			Detail	Subtotals	Percentages
Meals served to Patients:	Patient Days (excl. bed-hold days)		33,045		
	Meals per day		3	99,135	73.68%
Meals provided to Sisters:	Number of Sisters		21		
	Meals per day		3		
	Days per year		365	22,995	17.09%
Meals provided to Employees:	Breakfast	21 * 365	7,665		
	Lunch	10 * 365	3,650		
	Supper	3 * 365	1,095	12,410	9.22%
		Total Meals Served		134,540	100.00%

Reclassifications for Employee Meals:

Employee portion of total meals:	Total dietary costs	$ 314,345	*From page 3, Line 1, Col. 4*
	Employee percentage	9.22%	*From calcualtion above*
	Employee Portion of Dietary Costs	**$ 28,995**	***Reclass: From Line 1; To Line 22, Schedule V***
	Food cost	$ 210,539	*From page 3, Line 2, Col. 4*
	Employee percentage	9.22%	*From calcualtion above*
	Employee Portion of Food Cost	**$ 19,420**	***Reclass: From Line 2; To Line 22, Schedule V***
	Total Reclassifications for Employee Meals	**$ 48,415**	

Adjustments for Sisters' Maintenance:

Sisters' portion of dietary and food cost:	Dietary cost	$ 314,345	*From page 3, Line 1, Col. 4*
	Sisters' percentage	17.09%	*From calcualtion above*
	Sisters' Portion of Dietary Cost	**$ 53,727**	***Adjustment: To Line 1, Schedule V***
	Food cost	$ 210,539	
	Sisters' percentage	17.09%	*From calcualtion above*
	Sisters' Portion of Food Cost	**$ 35,984**	***Adjustment: To Line 2, Schedule V***

Sisters' portion of building and utilities:

Sisters' portion of building:	Convent (Sisters) Square Footage	2,464		*From prior year - no change per Marty*
	Total Square Footage	66,656		*From prior year - no change per Marty*
	Convent (Sisters) Offset Percentage		3.70%	
Sisters' portion of utilities:	Heat and Other Utilities	$ 98,678		*From page 3, Line 5, Col. 4*
	Sisters' percentage	3.70%		*From calcualtion above*
	Sisters' Portion of Heat and Other Utilities	**$ 3,648**		***Adjustment: To Line 5, Schedule V***
Sisters' portion of building depreciation expense:	Building Depreciation Exp	$ 42,252		*From G/L Account No. 782029*
	Sisters' percentage	3.70%		*From calcualtion above*
	Sister's Portion of Building Depreciation	**$ 1,562**		***Adjustment: To Line 36, Schedule V (also see p 13 of CR)***

Employee Benefits in Sisters' Meals:

	Dietary Salaries	$ 292,612		*From page 3, Line 1, Col. 1*
	Sisters' percentage	17.09%		*From calcualtion above*
	Salaries Applicable to Sister's Meals		$ 50,012	
	Total Salaries	$ 2,092,824		*From page 4, Line 45, Col. 1*
	Employee Benefits	$ 448,757		*From page 3, Line 22, Col. 4*
	Employee benefits ratio		21.4%	
	Employee Benefit Adjustment		**$ 10,724**	***Adjustment: To Line 22, Schedule V***
	Total Adjustments for Sisters' Portion of Costs		**$ 105,645**	

St Joseph Nursing Home

ID# 0005637

Report Period Beginning: 7/1/2001

Ending: 6/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,666)	0	0	0	0	0	0	0	0	0	0	(6,666)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,666)	0	0	0	0	0	0	0	0	0	0	(6,666)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(8,038)	0	0	0	0	0	0	0	0	0	0	(8,038)	20
21	Clerical & General Office Expenses	(6,454)	0	0	0	0	0	0	0	0	0	0	(6,454)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(14,492)	0	0	0	0	0	0	0	0	0	0	(14,492)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,158)	0	0	0	0	0	0	0	0	0	0	(21,158)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Joseph Nursing Home # 0005637 **Report Period Beginning:** 7/1/2001 **Ending:** 6/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(12,037)	0	0	0	0	0	0	0	0	0	0	(12,037)	36
37	**TOTAL Ownership**	(12,037)	0	0	0	0	0	0	0	0	0	0	(12,037)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,195)	0	0	0	0	0	0	0	0	0	0	(33,195)	45

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WORKSHEET NOT APPLICABLE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	WORKSHEET NOT APPLICABLE										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	WORKSHEET NOT APPLICABLE									2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	NONE											2
3												3
4												4
5												5
	Working Capital											
6	DAUGHTERS OF ST. FRANCIS											6
7	OF ASSISI	X		WORKING CAPITAL	NONE	VARIOUS	224,000	204,000	NONE	NONE	NONE	7
8												8
9	TOTAL Facility Related						$ 224,000	$ 204,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 224,000	$ 204,000			$ NONE	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	NONE	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Joseph Nursing Home COUNTY Marshall

FACILITY IDPH LICENSE NUMBER 0005637

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	WORKSHEET NOT APPLICABLE		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,656 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NOT APPLICABLE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Owned by Dauaghters			$	1
2	of St. Francis of Assisi	428,532	1965	25,700	2
3	TOTALS	428,532		$ 25,700	3

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1965	1965	$ 484,023	$ 10,533	VARIOUS	$ 7,934	$ (2,599)	$ 464,186	4
5	50		1969	1969	898,293	18,672	VARIOUS	15,650	(3,022)	859,170	5
6			1968	1968	451,401		25			451,401	6
7			1986	1986	3,877		12			3,877	7
8			1987	1987	5,840	389	15	389		5,643	8
	Improvement Type**										
9	MISC			1968	6,160		50			6,160	9
10	GARAGE			1972	2,491		50			2,491	10
11	FINISH BASEMENT			1973	6,343		50			6,343	11
12	WINDOW			1974	900		50			900	12
13	INSULATION			1976	21,986		50			21,896	13
14	ROOF			1980	16,049		50			16,049	14
15	MISC REMODELING			1981	7,711		10			7,711	15
16	IDPA AUDIT ADJUSTMENTS			1982	1,290		10			1,290	16
17	IDPA AUDIT ADJUSTMENTS			1983	877		10			877	17
18	IDPA AUDIT ADJUSTMENTS			1984	53,742		VARIOUS			53,742	18
19	IDPA AUDIT ADJUSTMENTS			1985	15,330		15			15,330	19
20	IDPA AUDIT ADJUSTMENTS			1969	28,119		20			28,119	20
21	IDPA AUDIT ADJUSTMENTS			1977	11,869	222	50	222		5,914	21
22	IDPA AUDIT ADJUSTMENTS			1986	94,429	647	VARIOUS	647		93,318	22
23	IDPA AUDIT ADJUSTMENTS			1989	146,038	11,579	VARIOUS	3,707	(7,872)	103,639	23
24	DECORATING			1987	3,285		10			3,285	24
25	PARKING LOT			1988	19,937	1,281	VARIOUS	1,281		19,491	25
26	FIRE ALARM SYSTEM			1990	37,956	1,886	VARIOUS	1,886		24,297	26
27	NEW ROOF			1992	55,787	2,789	10	2,789		55,787	27
28	HOT WATER TANK			1992	3,295	164	10	164		3,295	28
29	BUILDING PAINTING			1993	7,336		5			7,336	29
30	ROOF REPAIRS			1993	434	44	10	44		413	30
31	WATER HEATER			1993	223	15	15	15		142	31
32	BOILER REPAIR			1993	1,415	142	10	142		1,345	32
33	CODE ALERT FIRE SYSTEM			1995	8,559	1,006	VARIOUS	1,006		6,719	33
34	MISC			1997	3,013	302	5	302		3,013	34
35	VINYL FLOOR			1998	4,012	802	5	802		2,807	35
36	SUBTOTAL, PAGE 12				2,402,020	50,473		36,980	(13,493)	2,275,986	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SUBTOTAL, PAGE 12		$ 2,402,020	$ 50,473		$ 36,980	$ (13,493)	$ 2,275,986	37
38	CERAMIC FLOOR FOR NEW TUB	1999	107	5	20	5		18	38
39	CARPET ON WALLS	2000	2,668	534	5	534		1,335	39
40	METAMORA TELEPHONE SYSTEM	2000	7,337	734	10	734		1,835	40
41	TOMKAT ROOFING	2001	18,760	1,876	10	1,876		2,814	41
42	HOBERT CORP	2001	1,555	156	10	156		234	42
43	ASPHALT REPAIR	2002	2,900	181	8	181		181	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,435,347	$ 53,959		$ 40,466	$ (13,493)	$ 2,282,403	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 133,338	$ 14,609	$ 14,503	$ (106)	14	$ 62,127	71
72	Current Year Purchases	8,777	372	372		12.5	372	72
73	Fully Depreciated Assets	441,103					441,103	73
74								74
75	TOTALS	$ 583,218	$ 14,981	$ 14,875	$ (106)		$ 503,602	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING HOME	CHEVY CAPRICE	1987	$ 10,289	$	$	$		$ 10,289	76
77	NURSING HOME	PICK-UP	1995	14,590					14,590	77
78	NURSING HOME	MISC. OTHER	VARIOUS	5,676					5,676	78
79	NURSING HOME	2001 DODGE RAM 3500 VAN	2002	19,135	2,392	2,392		4	2,392	79
80	TOTALS			$ 49,690	$ 2,392	$ 2,392	$		$ 32,947	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,093,955	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 71,332	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,733	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,599)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,818,952	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	SISTERS SHARE OF BUILDING	$ 63,491	$ 1,562	$ 62,152	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 63,491	$ 1,562	$ 62,152	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WORKSHEET NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		5,380		5,380
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			750		750
9	TOTALS		$	$ 6,130	$	$ 6,130
10	SUM OF line 9, col. 1 and 2	(e)	$ 6,130			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ none

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs	WORKSHEET NOT APPLICABLE						2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 104,926	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,600)	249,911		3
4	Supply Inventory (priced at Cost)	25,516		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 380,353	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	79,003		13
14	Buildings, at Historical Cost	1,542,375		14
15	Leasehold Improvements, at Historical Cost	208,782		15
16	Equipment, at Historical Cost	1,210,906		16
17	Accumulated Depreciation (book methods)	(2,397,212)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Board-Designated Assets	24,630		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 668,484	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,048,837	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,937	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	25,000		29
30	Accrued Salaries Payable	96,363		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 183,300	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Motherhouse	204,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 204,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 387,300	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 661,537	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,048,837	$	48

*(See instructions.)

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 671,682	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 671,682	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(10,145)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (10,145)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 661,537	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,154,929	1
2	Discounts and Allowances for all Levels	(879,345)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,275,584	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	866	11
12	Gift and Coffee Shop	961	12
13	Barber and Beauty Care	19,616	13
14	Non-Patient Meals	5,705	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,088	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 37,236	23
	D. Non-Operating Revenue		
24	Contributions	50,671	24
25	Interest and Other Investment Income***	1,118	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,789	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	SISTERS MAINTENANCE	43,201	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,201	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,407,810	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	903,978	31
32	Health Care	1,544,595	32
33	General Administration	828,542	33
	B. Capital Expense		
34	Ownership	73,505	34
	C. Ancillary Expense		
35	Special Cost Centers	16,418	35
36	Provider Participation Fee	50,917	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,417,955	40
41	**Income before Income Taxes (line 30 minus line 40)****	(10,145)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (10,145)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,512	1,665	$ 36,089	$ 21.68	1
2	Assistant Director of Nursing	1,464	1,632	31,672	19.41	2
3	Registered Nurses	11,037	14,692	259,764	17.68	3
4	Licensed Practical Nurses	8,766	9,292	151,940	16.35	4
5	Nurse Aides & Orderlies	46,448	67,153	607,617	9.05	5
6	Nurse Aide Trainees	7,030	4,410	67,022	15.20	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,003	4,755	56,229	11.83	8
9	Activity Director	1,912	2,080	27,280	13.12	9
10	Activity Assistants	5,586	10,283	68,992	6.71	10
11	Social Service Workers	5,376	6,315	75,602	11.97	11
12	Dietician					12
13	Food Service Supervisor	2,016	2,080	30,021	14.43	13
14	Head Cook	1,880	2,080	25,073	12.05	14
15	Cook Helpers/Assistants	17,716	13,230	137,608	10.40	15
16	Dishwashers	11,536	8,584	99,821	11.63	16
17	Maintenance Workers	3,763	4,180	59,520	14.24	17
18	Housekeepers	11,537	11,488	91,622	7.98	18
19	Laundry	10,505	13,082	80,289	6.14	19
20	Administrator	1,966	2,080	78,300	37.64	20
21	Assistant Administrator	1,966	2,080	42,720	20.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,532	7,476	87,120	11.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,137	4,484	36,707	8.19	31
32	Other Health Care(specify)	1,840	2,080	33,995	16.34	32
33	Other(specify)	1,530	1,552	15,526	10.00	33
34	TOTAL (lines 1 - 33)	164,058	196,753	$ 2,200,529 *	$ 11.18	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	118	$ 5,082	1	35
36	Medical Director				36
37	Medical Records Consultant	48	1,958	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant	168	1,200	10	39
40	Physical Therapy Consultant	9	275	10	40
41	Occupational Therapy Consultant	26	1,288	10	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	29	1,453	10	43
44	Activity Consultant	24	1,255	11	44
45	Social Service Consultant	28	1,845	12	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	450	$ 14,356		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	8	233	10	51
52	Nurse Aides	581	11,673	10	52
53	TOTAL (lines 50 - 52)	589	$ 11,906		53

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas Becher	Administrator	0	$ 78,300
Martha Schlink	Asst Administrator	0	42,720
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,020

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Achieve Software		$ 5,150
Valuation Counselors		750
Computerland		2,755
Clifton Gunderson		8,400
CBIZ, Business Solutions		4,700
Circle of Quality		17,006
OSF Medical Group		1,650
Small, Parker & Blossom		2,400
Dr. Kaplan, DDS		1,824
Deanna Batstone		600
Ballard, Folkins, Nussbaum		7,850
Industrial Data Design		986
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 54,071

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 13,481
Unemployment Compensation Insurance	
FICA Taxes	149,815
Employee Health Insurance	261,016
Employee Meals	48,415
Illinois Municipal Retirement Fund (IMRF)*	
Pension expense	53,492
Employee benefits	5,754
Sisters maintenance adjustment	(10,724)
TOTAL (agree to Schedule V, line 22, col.8)	$ 521,249

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Schedule Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,632
Health Care Worker Background Check	
(Indicate # of checks performed 57)	684
Misc. Dues and Licenses	5,386
Public Relations	5,145
Non-allowable Advertising	1,088
Yellow page advertising	1,805
Less: Public Relations Expense	(5,145)
Non-allowable advertising	(1,088)
Yellow page advertising	(1,805)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,702

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,234
Van maintenance & Gas	1,431
Seminar Expense	4,700
Nurses aide training comp test reclass	(750)
Nurses aide training reimb. adjustment	(866)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,749

* Attach copy of IMRF notifications

**See instructions.

ST. JOSEPH NURSING HOME
SCHEDULE XIX, G, PAGE 21 - SCHEDULE OF TRAVEL AND SEMINAR
Year Ended June 30, 2002

SEMINAR NAME	EMPLOYEE(S)	DATE	COST
Illinois Health Care Conference	All Staff	8/24/2001	$725.00
CPR Class	Nursing	9/19/2001	$60.00
Achieve Healthcare	M.Schlink	10/17/2001	$45.00
O.C.C.	T. Becher		
	M. Cutler	1/17/2002	$270.00
CPR Class	Nursing	2/22/2002	$180.00
IOC	T. Becher		
	M. Schlink	3/15/2002	$200.00
	M. Cutler		
	B. Hill	3/15/2002	$200.00
HIPAA	T. Becher		
	M. Schlink	5/17/2002	$250.00
IL Nursing Home Admin	T. Becher		
	M. Schlink	5/17/2002	$130.00
HIPAA	M. Cutler	6/20/2002	$99.00
Dietary Mgr. Assn	J. Hufnagel	10/18/2001	$25.00
MDS	J. Hufnagel	10/23/2001	$79.00
MDS	A. Taliani	10/23/2001	$79.00
Medical Education	D. Hagemeier	11/20/2001	$97.00
University of NC	D. Hagemeier	1/2/2002	$165.00
Proctor Hospital	C. Bergen	8/9/2001	$100.00
MDS	K. Major		
	C. Bergen		
	M. Cutler		
	B. Hill	8/13/2001	$316.00
Geriatric Conference	D. Kingsley		
	C. Bergen		
	K. Buennemeyer	8/22/2001	$240.00
C N A Instructor. Course	J. Kissee	4/5/2002	$55.00
Wound/Skin Mgmt.	C. Bergen		
	P. Whitney	4/10/2002	$50.00
MDS Advanced	C. Bergen		
	B. Hill	6/5/2002	$335.00
IL Act. Professionals	A. Taliani	8/3/2001	$130.00
Outcome Services	A. Taliani	4/3/2002	$70.00
Ramirez Consulting-			
Activity Profess –36 Hr.	A. Taliani	6/26/2002	$50.00
Nurses aide training competency tests			$750.00
Total Seminar Expense, before reclasses and adjustments			**$4,700.00**

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2	WORKSHEET NOT APPLICABLE												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Joseph Nursing Home # 0005637 Report Period Beginning: 7/1/2001 Ending: 6/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Catholic Health Assoc, AAHSA, Life Services Network, Lacon Chamber of Commerce**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **6**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,663** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **50,917**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **YES-Sisters (no costs)** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **48,415** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **5,705**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **MAYER, HOFFMAN & McCANN P.C.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees